

# 2011 Military Health System Conference

## The Patient Safety Reporting System (PSR)

*The Quadruple Aim: Working Together, Achieving Success*

Michael Datena; Carmen Birk; Suzie Farley; Beverly Thornberg, Lt Col, USAF; Jorge Carrillo, LTC, USA

January 24, 2011



TRICARE Management Activity Office of the Chief Medical Officer  
Department of Defense Patient Safety Program

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# Session Objectives



- Become familiar with the Patient Safety Reporting System that is currently being deployed across the direct care facilities.
- Understand the capabilities of the system and the importance of capturing both medication and non-medication patient safety events in a standardized format which facilitates event capture, analysis, trending and learning from patient safety occurrences.
- This session will consist of the following:
  - 1. Discussion of the PSR application, application benefits, planned product enhancements, aggregate data to date
  - 2. Service representatives will discuss PSR use and implementation from the Service Headquarters perspective
  - 3. Lessons learned from an experience PSR user at the local MTF level
  - 4. Roll out schedule of pending site implementations

# DoD Patient Safety Program



- A comprehensive, centralized program with the goal of establishing a culture of patient safety and quality within the MHS
- Established under the 2001 Department of Defense Instruction (DoDI) 6025.17
- DoD PSP identifies and reports actual and potential problems in medical systems and processes and to implement effective actions to improve patient safety and health care quality throughout the MHS

***Our Mission*** is to promote a culture of safety to eliminate preventable patient harm by engaging, educating and equipping patient-care teams to institutionalize evidence-based safe practices.

***Our Vision*** is to support the military mission by building organizational commitment and capacity to implement and sustain a culture of safety to protect the health of the patients entrusted to our care.

# MHS Quadruple Aim



## Readiness

Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.

## Experience of Care

Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.



## Population Health

Reducing the generators of ill health by encouraging healthy behaviors and decreasing the likelihood of illness through focused prevention and the development of increased resilience.

## Per Capita Cost

Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.

# Why is Reporting Important?



- It's important – to keep our patients safe
  - 44,000 – 98,000 deaths/year (IOM 1999)
  - \$17 – \$29B annually Lost income, production, disability and healthcare costs
    - Over half healthcare costs
  - 1.5M preventable adverse drug events annually in U.S. (IOM 2006)
    - \$3.5B annual estimate
- In the DoD:
  - Approximately 128,000 potential and actual events reported in 2009

# Capabilities



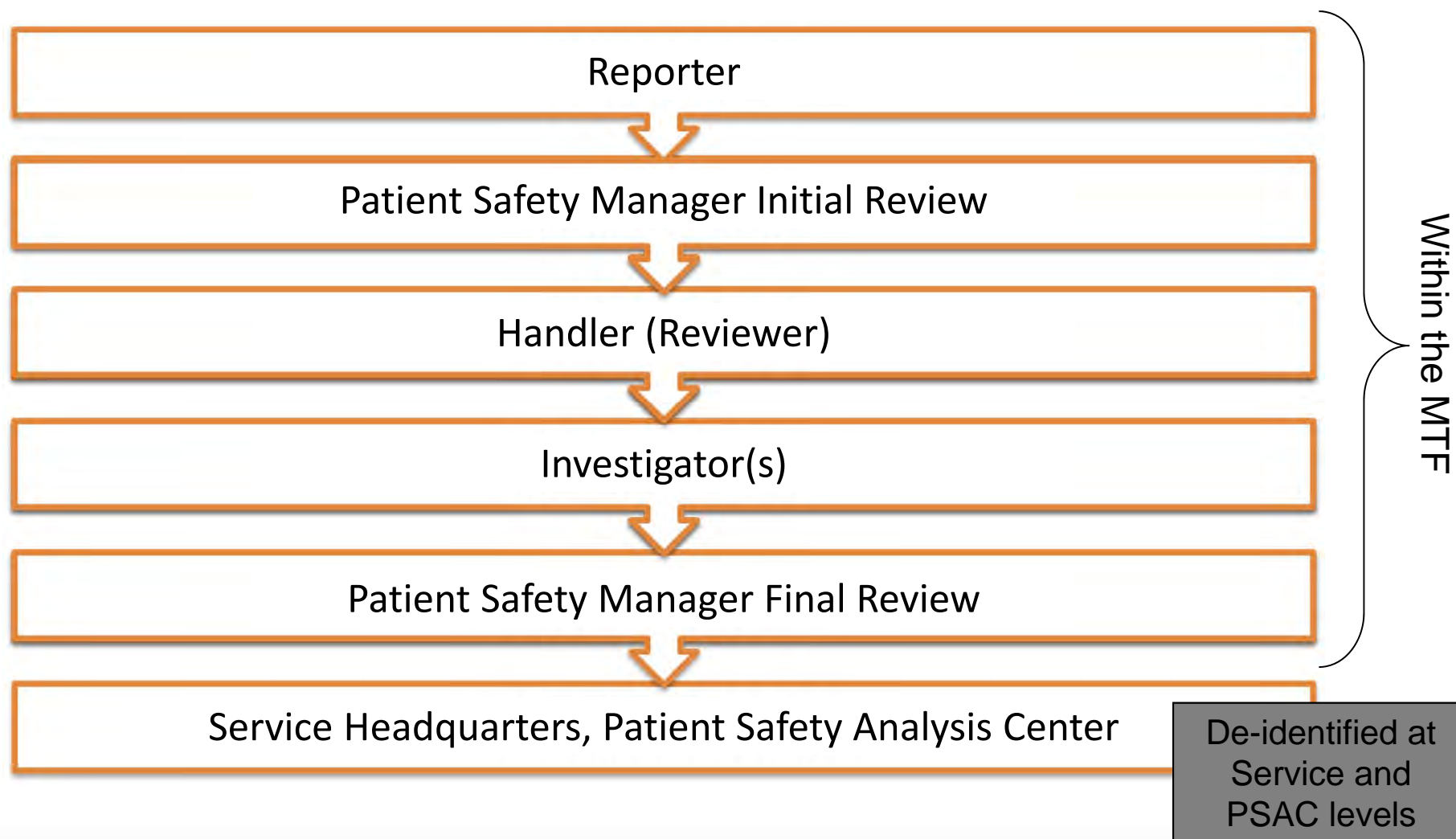
- **Broadly applicable:** Commercial Off-the-Shelf (COTS) reporting system
- **Maintains confidentiality:** Supports anonymous reporting
- **Easily Assessable:** Web-based application
- **Secure:** Supports role-based security; CAC enforced
- **Simple to use:** Intuitive point and click, drop downs, text for the user
- **Promotes information sharing:** Automates the non-standardized paper-based systems

# Benefits



- **Helps improve patient safety**
  - Promotes depth of information necessary for the proactive improvement of patient safety
  - Supports the local, Service and enterprise-wide safety improvement strategy through systematic methodologies and comprehensive analytic tools
- **Enables greater ability to learn and share safety information**
  - Consolidates both medication and non-medication events in one tool
  - Standardizes data capture and taxonomy
  - Centralizes capture, collection and aggregation of event level data
  - Begins alignment with AHRQ Common Formats
- **Promotes fiscal responsibility**
  - Facilitates cost avoidance by reduction of preventable and avoidable health care events
- **Addresses DOD and Congressional Requirements**
  - Responds to the 2001 National Defense Authorization Act (NDAA) and DoD 6025.13

# Typical Event Flow





12 October 2010



Report Event : Login : Register

## Patient Safety Event Reporting Form

Reporting is anonymous unless reporter detail is completed

A ★ indicates a required field.

Click the ? icon for help with a particular field.

Click the ▾ button to view and select from the list of available options for that field.

Once submitted the event report is locked. User may not save draft report.

Issues with the PSR system should be reported to the MHS Help Desk:  
Send email to mhssc@timpo.osd.mil or mhs\_remedy@timpo.osd.mil or call 1-800-600-9332.

### Event details

This section asks you to detail *When, Where and What* happened.

★ Event date  
(mm/dd/yyyy)

★ Event time  
(24 hour local time)

Discovery date  
(mm/dd/yyyy)

★ Service Affiliation  
Please select the Service where  
the event occurred

★ Service Region

★ Parent MTF

★ MTF

★ Department/Division/Directorate

★ Clinic/Service

★ Location Type

★ Event description  
Enter facts, not opinions. Do not  
enter names of people

★ Immediate action taken  
What actions were taken to  
prevent patient harm or lessen the  
impact?

What do you think caused the  
event?

When

Selecting Down  
Arrows  
Displays Pick  
lists

Where

What

# Sample PSR Report Form

Reporter's Recommendations  
What would prevent this type of  
event occurring in the future?

Patient Status

Was the provider notified?

Was the patient in transit?

Answering "Yes"  
opens Provider  
section

### Required Information

Answer Yes to all statements that apply - doing so will cause additional sections of the form to appear.

★ Was a patient involved?

Answering "Yes" opens  
Patient section

★ Was this a medication event?

★ Was equipment/material  
involved?

Are there other people with  
information on this event?

Are there any documents to be  
attached to this record?

Answering "Yes" to either the  
medication or Equipment  
material sections opens up the  
additional sections

### Details of person reporting the event.

Last Name

First Name

Status

Status detail

E-mail

If you wish to receive an e-mail  
confirmation please enter your  
work (.mil) e-mail address here

Telephone

Optional

Click "Submit"  
when finished

DO NOT PRINT! All information is subject to the Privacy Act of 1974, 5 USC 552 and 10 USC 1102. This is a protected quality assurance document.

Submit Cancel

For Official Use Only. All information is  
subject to the Privacy Act of 1974, 5 USC  
552 and 10 USC 1102



# Major Implementation Milestones



- 44 sites online, 93 sites scheduled between now and 30 June 2011
- Completing and submitting hierarchy
- Determining who will have PSM and Reviewer roles
  - Get them registered
  - Complete AARF
- 45, 30, 15 day Pre-implementation meetings
  - Provide information
  - Assess readiness for training and implementation
- Training
  - Typically 3 – 5 days depending on facility size
    - Instructor led
      - PSM (8 hrs)
      - Reviewer/Investigator (4 hrs)
  - Web-based training available for all roles including reporter
- Implementation
  - Immediately following training

# Planned Enhancements



- Next version 10.2
- Overall enhancements
  - Approval status fields
  - Type ahead
  - Enhanced e-mail notifications
- Improvements to Searching and Reporting
  - Extra fields
  - Stacked bar, stoplight, gauges, change orientation etc
  - Define listing reports

# 2011 Military Health System Conference

## *PSR Reporting – Air Force Perspective*

Implementation & Early Lessons Learned

*The Quadruple Aim: Working Together, Achieving Success*

Lt Col Beverly Thornberg, USAF, NC, DHA(c), MHA, RNC

January 24, 2011



United States Air Force

# Overview



- Limited Deployment Sites
- Full Deployment Sites
- Challenges
- Successes



# Limited Deployment



- Limited Deployment Sites:
  - Wilford Hall Medical Center: San Antonio, TX
  - Malcolm Grow Medical Center: Joint Base Andrews, MD
  - Davis-Monthan Medical Group: Tucson, AZ

# Full Deployment



- Full Deployment Sites Implemented to date:
  - Bolling Air Force Base (AFB)
  - Langley AFB
  - Hanscom AFB
  - MacDill AFB
  - Wright-Patterson AFB
  - Seymour Johnson AFB
  - Whiteman AFB
  - Robins AFB
  - Little Rock AFB
  - Patrick AFB
  - Cannon AFB
  - Keesler AFB
  - Dover AFB
  - Maxwell AFB
  - McGuire AFB
  - Altus AFB

# Challenges



- Aggressive Training Schedule: Increased man hours on regional managers
- MTF Leadership Support Early In The Process: Support in completing security forms
- Sustainment After Training Is Completed: Recommend a recorded DCO/Continued WBT
- Transition From MMSR & JAMRS to PSR
- Role of Champions (Reviewer/Handler or SuperUser): Key to complete & accurate reporting for usable analysis
- Local Access Issues: Not the PSR system

# Successes



- Regional Managers at *Air Force Medical Operations Agency* Involvement With Each MTF (75 total):  
Working together for success
- Reporting Increased Already!
  - 3 facilities reporting 4-52% more
- Tier 3 Support to Resolve Issues Rapidly
- PSR Has Broadened the Number of Reporters
- New Staff Involvement: Significant increase in reporting
- Already Using the Data

# 2011 Military Health System Conference

## *PSR Reporting – Navy Approach*

*The Quadruple Aim: Working Together, Achieving Success*

Carmen C. Birk, RN, MS

January 24, 2011



Navy Bureau of Medicine and Surgery

# Navy Implementation Strategy



An Implementation Strategy to Ensure Success!



**Ensure Leadership  
Commitment and  
Support**

**Set Benefits  
Expectations and  
Targets**

**HQ Staff  
Participation in  
Site Training**

**Monitor Progress  
and Document  
Lessons Learned**

# Navy Implementation Strategy



- Ensure Leadership Commitment and Support
  - High visibility at SG Level
  - Championed by Command Leaders
  - Ownership and involvement by RM/PS
  - Support for staff training and transitioning to new reporting requirements



# Navy Implementation Strategy



- Set benefits expectations and targets for an improved Event Reporting process
  - Increase in events reported
  - Expedite review and referral timeline
  - Consolidated record of problems and issues
  - Ability to perform real-time event tracking and trending at MTF level
  - Comprehensive data available at HQ level for event analysis

# Navy Implementation Strategy



- Include HQ staff participation in site training
  - Support RM/PS ownership of and involvement in PSR implementation and use
  - Reinforce communication policies and procedures
  - Address and resolve issues as they arise

# Navy Implementation Strategy



- Monitor progress and document lessons learned
  - Coordinate with site to ensure implementation schedule stays on target
  - Incorporate training updates into implementation process
  - Compile site experiences to share

# Navy Implementation Strategy



- Next Steps
  - Follow up on progress of implemented sites
    - Continue to troubleshoot user problems and resolve issues
  - Establish new baseline for Navy Medicine event reporting
    - Define HQ process for receipt and analysis of aggregate data

# 2011 Military Health System Conference

## *PSR Reporting – A Military Treatment Facility's Perspective*

*The Quadruple Aim: Working Together, Achieving Success*

Suzie Farley

January 24, 2011




National Naval Medical Center, Bethesda

# MTF Pre Implementation



- Plan
  - Develop the communication algorithm for flow of an event
  - Determine reviewers/investigators
  - Establish a contingency plan
  - Brief Leadership on benefits of the PSR system
  - Involve Middle Managers in process flow
- Market
  - Announce the PSR deployment to staff
  - Accessing the PSR
  - Review what to report





# PATIENT SAFETY REPORTING PROGRAM

## How To REPORT

**5 Easy Steps for Using the Patient Safety Reporting System**

1. Open your NNMC intranet browser and Click on PSR icon
2. Fill out the When? Where? & What? sections.
3. Enter other information as required.
4. Optional: Enter your information, or leave blank if you wish to remain anonymous.
5. Submit your report


## WHAT TO REPORT

**Near Misses** An event or situation that did not reach the patient but could have resulted in harm but didn't, either by chance or timely intervention.

**Adverse Events** An event that reached the patient and either did or didn't cause harm.

**Sentinel Events** Unexpected occurrences involving death or serious physical or psychological injury or risk thereof

## PATIENT SAFETY EVENT REPORTING FORM



The Patient Safety Reporting System (PSR) icon located at the top of the intranet homepage gives you access to the electronic event reporting form.

## WHAT TO REPORT ON PATIENT SAFETY FORMS

(Events are QA protected, confidential & privileged under 10 USC 1102)

- Delay in diagnosis
- Patient identification errors
- Unanticipated surgical intervention required
- Increased length of stay or level of care
- Overuse/other procedures initiated
- Hospital acquired infections
- Unanticipated outcomes of care (near misses)
- Loss of function (sensory, motor, physiologic, intellectual)

- Medication errors
- Policy not followed
- Falls
- Disengagement
- Documentation errors
- If in doubt, report!

**Sentinel Event (report within 24 hours)**

- Unanticipated death
- Surgery on the wrong patient or wrong body part
- Unanticipated death of a full-term infant
- Radiation overdose or radiation to wrong body region
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Major permanent loss of function (sensory, motor, physiologic, intellectual)
- Abduction of any patient receiving care, treatment, and services (adult or within 72 hours of discharge)
- Severe neonatal hyperbilirubinemia (> 30 mg/dl)
- Hemolytic transfusion reaction
- Infant discharged to the wrong family
- Rape

Patient Safety is Everyone's Responsibility



# Handling our patients with

# PSR

# safety and care

**Patient Safety Reporting Launch Party**

Date: 1 April 2010  
Location: Clark Auditorium  
Time: 1000 - 1400





# MTF Training



- Train
  - Middle Managers on event process
  - Reviewers and investigators on roles and responsibilities
  - New harm classification definitions



- Throw a kick off party
  - Engaged Commander and leaders
- Held weekly meetings with reviewers and investigators
  - Supported and problem solved
- Attended Department Head meetings
  - Established checks and balances

# Sustainment



- Updating reviewers/investigators regularly
  - Account Authorization Request Forms (AARF)
  - Continuous training
- Disseminating lessons learned
  - Prepare to be flexible
  - New users already requesting customized data reports
    - Excel proficiency essential
  - Increase focus on training on event categories

# 2011 Military Health System Conference

## *PSR Reporting – Army Approach*

### *Medication Safety Focus*

*The Quadruple Aim: Working Together, Achieving Success*

LTC Jorge D. Carrillo, PharmD, MS, BCPS

January 24, 2011



US Army Medical Command

# Army Implementation Strategy



- Limited Deployment Sites:
  - Madigan Army Medical Center, Ft Lewis, WA
  - Martin Army Community Hospital, Ft Benning, GA
  - Kimbrough Army Ambulatory Health Clinic, Ft Meade, MD

# Army Implementation Strategy (Cont)

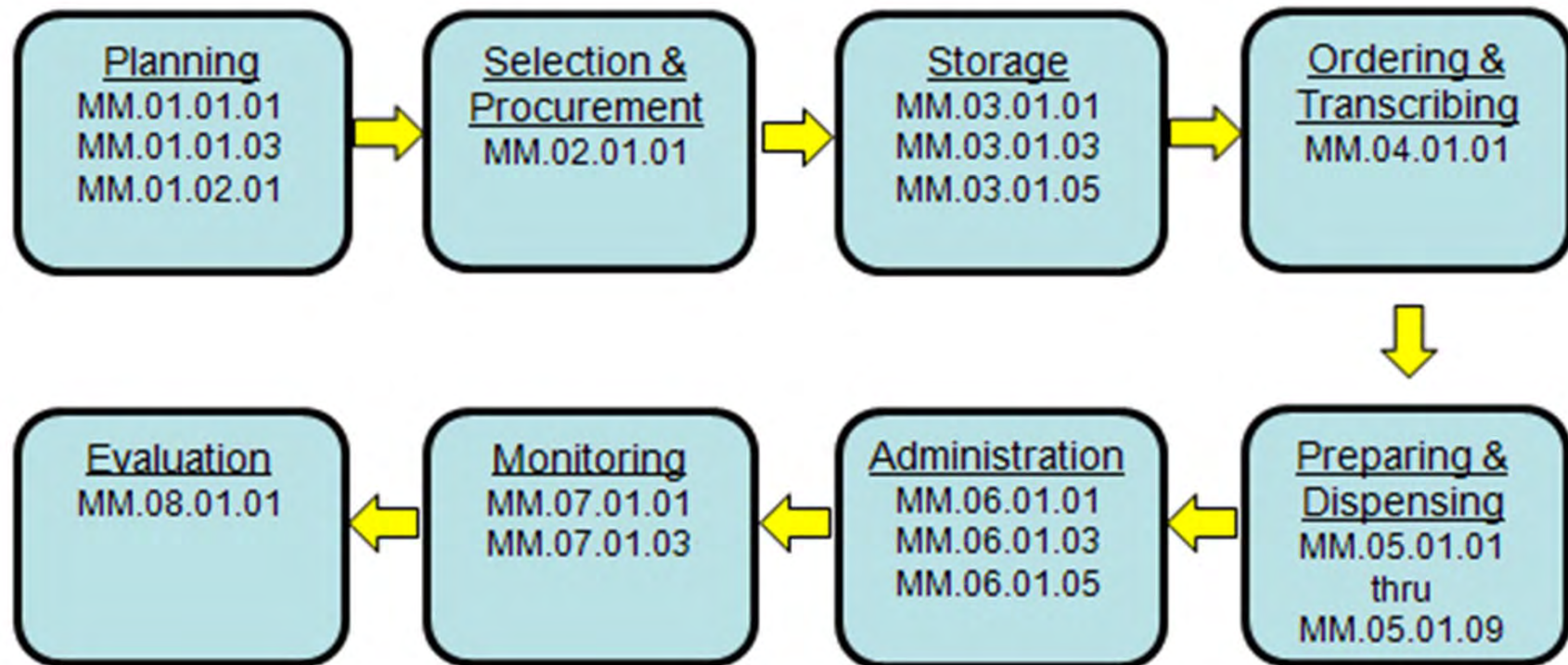


- Partnership with Regional Medical Commands
- CoS Implementation Memo – Nov 2010
- Full Deployment Schedule
  - NRMCC – Nov to Dec 10
  - SRMC – Nov 10 to Feb 11
  - WRMC – Jan to Apr 11
  - PRMC – Apr to May 11
  - ERMCC – May to Jun 11
  - DENCOM – May to Jun 11
- Transition of PS Data Reporting to HQ

# Medication Safety Focus



## ■ Medication Use Process



# Medication Safety Focus



**INCIDENT REPORT**  
For use at VA Medical Centers and VA Medical Clinics

Quality Management Document under 101.001.102. Copies of this document and/or information will not be further released under penalty of the law. Unauthorized disclosure carries a statutory penalty of up to \$2,000 in the case of a first offense, and up to \$2,000 in the case of a subsequent offense. In addition to these statutory penalties, unauthorized disclosure may result in administrative action, including suspension from military or civilian service.

Instructions: One page 2 to be submitted to the nearest medical center or medical clinic with the incident report.

1. DATE OF EVENT: mm/dd/yyyy 2. TIME OF EVENT: mm/dd/yyyy 3. LOCATION OF EVENT: \_\_\_\_\_

4. This incident was seen/observed by: ☐ Actual Event/Observer ☐ Med/Med/Observer

5. This incident involved the following individual(s): (Name of patient) ☐ Yes ☐ No

6. Patient: ☐ Family Member ☐ Adult ☐ Child ☐ Adolescent ☐ Staff Member ☐ Visitor ☐ Volunteer ☐ Other

7. Type of Event: (Check all that apply) ☐ Medication Error ☐ Patient Safety ☐ Other (Specify) \_\_\_\_\_

8. Effect of this incident: ☐ No harm ☐ Minor harm ☐ Moderate harm ☐ Major harm

9. Name: \_\_\_\_\_

10. Department: \_\_\_\_\_

11. Supervisor: \_\_\_\_\_

12. What action, if any, was taken? \_\_\_\_\_

13. Patient's Place of Residence: \_\_\_\_\_

14. Address: \_\_\_\_\_

15. City: \_\_\_\_\_

16. State: \_\_\_\_\_

17. Zip: \_\_\_\_\_

18. Date of Report: \_\_\_\_\_

19. Report by: \_\_\_\_\_

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**PSR**

16 November 2010 **Datix**

**Report Event : Login : Register**

**△ Patient Safety Event Reporting Form**

**Reporting is anonymous unless reporter detail is completed**

A \* indicates a required field.

Click the icon for help with a particular field.

Click the button to view and select from the list of available options for that field.

Once submitted the event report is locked. User may not save draft report.

Issues with the PSR system should be reported to the MHS Help Desk:  
Send email to [mhssc@timpo.osd.mil](mailto:mhssc@timpo.osd.mil) or [mhs\\_remedy@timpo.osd.mil](mailto:mhs_remedy@timpo.osd.mil) or call 1-800-600-9332.

**Event details**

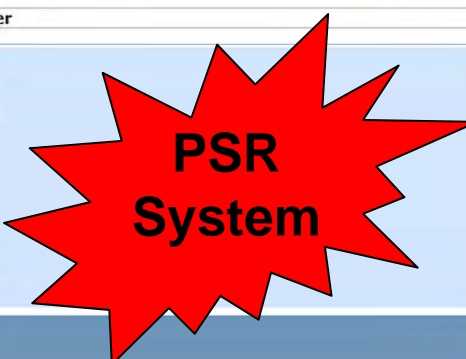
This section asks you to detail *When, Where and What* happened.

\* **Event date** (mm/dd/yyyy)

\* **Event time** (24 hour local time)

\* **Discovery date** (mm/dd/yyyy)

\* **Service Affiliation**



# This section asks you to detail *When, Where and*

**\* Event date**  
(mm/dd/yyyy)

**\* Event time**  
(24 hour local time)

**Discovery date**  
(mm/dd/yyyy)

**\* Service Affiliation**

Information is used by the FBI to determine if the information is relevant to the FBI's mission. The FBI will use the information to determine if the information is relevant to the FBI's mission. The FBI will use the information to determine if the information is relevant to the FBI's mission.

For more information, please contact the FBI's Office of Information Management. The FBI's Office of Information Management is responsible for the collection, management, and dissemination of information. The FBI's Office of Information Management is responsible for the collection, management, and dissemination of information.

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# Medication Safety Focus



- Pharmacy & Patient Safety Collaboration
- Increased Visibility of Medication Events
- Reporting of Adverse Drug Events
  - Medication Errors & Adverse Drug Reactions
- Standard Pharmacy Reports
- Pharmacy-Specific PSR Training
- Collaboration with the Institute for Safe Medication Practices (ISMP)

# *PSR Reporting – Conclusions*

*The Quadruple Aim: Working Together, Achieving Success*

January 24, 2011



TRICARE Management Activity Office of the Chief Medical Officer  
Department of Defense Patient Safety Program

# Implementation Challenges



- Transparency and Trust
- Three Services with very different cultures
- Existing reporting culture
  - Paper based reporting vs. electronic
  - “Tick-mark” reporting vs. text-based
- Expectation management
  - Customization
  - Transition to standardization
    - Agreement on taxonomy
    - Appropriate use of that taxonomy
    - Efforts to ease the transition
- Aggressive (8-month) full deployment schedule

# Lessons Learned



- Leadership engagement
- User Buy-in
- Methods to accelerate integration process
  - Webinars
  - Weekly Office Hours
- Understanding implications of reporting culture shift from paper-based to web-based
- Importance of getting the site hierarchies correct

# PSR Success Story



- A system that provides the data granularity necessary to implement change and make our facilities safer for our patients
- Functional community engaged
- Good functional/IT community partnership
- Good Government/Vendor partnerships

# Conclusions



- Reporting is good!
- Encourage reporting
- Routinely review and discuss trends
- “If you don’t report them you can’t fix them”
- The culture of safety begins with all of us!



McClinton died after being injected with chlorhexidine, an antiseptic, during a procedure for a brain aneurysm. The antiseptic was mistaken for another substance to be used in the procedure.



A third premature baby has died after being given an overdose of an anti-clotting drug in an Indianapolis hospital.



Laurie Johnston, Ontario, Canada healthy breast removed in error...

# Questions?



For more information, contact your Service POC:

Army: [jorge.carrillo@amedd.army.mil](mailto:jorge.carrillo@amedd.army.mil)

Air Force: [beverly.thornberg@lackland.af.mil](mailto:beverly.thornberg@lackland.af.mil)

Navy: [carmen.birk@med.navy.mil](mailto:carmen.birk@med.navy.mil)

Michael.Datena@tma.osd.mil

<http://health.mil/dodpatientsafety>

